STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155242	A. BUILDING _____ B. WING _____	C 09/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF MUNCIE	**4301 N WALNUT ST MUNCIE, IN 47303**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00156709.

This visit was in conjunction with the Recertification and State Licensure Survey.

Complaint IN00156709 unsubstantiated due to lack of sufficient evidence.

Survey dates: September 22, 23, 24, 25, and 26, 2014

Facility number: 000146
Provider number: 155242
AIM number: 100291200

Survey Team:
Toni Maley, BSW, TC
Ginger McNamee, RN
Karen Lewis, RN
Tina Smith-Staats, RN

Census bed type:
SNF/NF: 120
Total: 120

Census payor type:
Medicare: 16
Medicaid: 97
Other: 7
Total: 120

Sample: 7

Signature Healthcare of Muncie was found to be in compliance with 42 CFR 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Complaint IN00156709. Quality review completed by Debora Barth, RN.	F 000		